MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

ADMISSION/ANNUAL HISTORY AND PHYSICAL

Effective Date: December 15, 2015 **Policy #:** PH-06

I. PURPOSE: To provide guidelines for assessing patients' medical needs while they are at Montana State Hospital (MSH).

II. POLICY:

A. A comprehensive medical history and physical health assessment will be completed for each patient admitted to MSH. For patients who remain hospitalized for extended periods, a physical health examination will be repeated at least annually determined by the patient's date of admission.

B. Significant findings from the history and physical process will be used in the treatment planning process.

C. All Admission/Annual History and Physicals become a permanent part of the medical record.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. Licensed Independent Practitioners (LIPs) are responsible for completing history and physical health assessments according to policy.

B. Health Information is responsible for tracking when the annual history and physical health assessment is due and notifying the Medical Clinic, and the Medical Staff.

V. PROCEDURE:

A. Admission History and Physical:

1. The Admission History and Physical includes a medical history and physical examination performed by a primary care LIP within twenty-four (24) hours of admission.

2. If a patient's psychiatric acuity prevents completing a full history and physical, an evaluation will be done from the available records, accompanying

information and observations. The psychiatric LIP will request a follow up evaluation if indicated.

3. The Medical History will include:

    a. History of present illness.

    b. Medical history;

    c. Medications and allergies;

    d. Social history including;

    e. Habits including the uses of caffeine, tobacco, alcohol, and/or street drugs.

    f. Family History;

    g. Review of systems.

4. The Physical Examination will be a complete head-to-toe assessment including a neurological examination. See the attached format (Attachment A) for the Physical Examination.

5. Documentation of the Admission History and Physical will conclude with diagnoses and plan.

B. Annual History and Physical:

1. Every long-term patient will be scheduled for a complete history and physical at least annually based on the patient's date of admission.

2. If the patient repeatedly refuses to cooperate, a limited evaluation will be done using information in the medical record, communication with staff, and those examination procedures which can be completed.

3. The annual history and physical will be done in the same format as the Admission History and Physical focusing on, but not limited to:

    a. Review of medical history over the past year;

    b. Review of systems;

    c. Physical examination; and

d. Treatment planning related to physical health deficits and/or maintenance needs.

C. Laboratory and Diagnostic Services

1. The physical health examination process may result in the need for laboratory and other invasive diagnostic and imaging procedures for baseline purposes or in response to specific findings. The primary care LIP will order tests in accordance with the standard of care/clinical need.

D. Documentation

1. All history and physical examinations are transcribed and become a permanent part of the medical record.

2. Ongoing medical treatment issues will be documented in the Consultation section of the medical file. Orders and instructions for follow-up will be written on the Physician Order Sheets.

VI. REFERENCES: None

VII. COLLABORATED WITH: Medical Clinic LIPs, Director of Health Information.

VIII. RESCISSIONS: #PH-06, *Physical Health Assessment* dated July 13, 2009; #PH-06, *Physical Health Assessment* dated August 22, 2006; #PH-06, *Physical Health Assessment* dated March 31, 2003; #PH-06, *Physical Health Assessment* dated February 14, 2000; H.O.P.P. #PH-03-96-N, *Physical Health Assessment*, May 8, 1996

IX. DISTRIBUTION: All hospital policy manuals

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XII. ATTACHMENTS:

A. Admission History and Physical template
B. Annual History and Physical template

_____/___/__	_____/___/__
John W. Glueckert Date	Thomas Gray, MD Date
Hospital Administrator	Medical Director

MONTANA STATE HOSPITAL
ADMISSION HISTORY & PHYSICAL
, 2014

MSH#:
Date of Admission:
Date of Evaluation:

Chief Complaint:
1.
2.

History of Present Illness: This is a admitted from

During evaluation today,

Medical History:
Hospitalizations: This is patient's admission to MSH. Past Psychiatric History: Past Medical History: Past Surgical History:

Medications:
Psychiatric:
Medical:

Allergies:

Family History:

Social History:

Habits:

Systems Review:
HEENT:
CVR:
GI:
GU:
MS:
NEURO:

PHYSICAL EXAMINATION

Temperature:	Pulse:	Respirations:
B/P:	O_2 sat % on room air.	
Height:	Weight: lbs.	

General: The patient is pleasant, non-toxic appearing, breathing comfortably, in no apparent distress.

HEENT:

CVR:

Abdomen:

Breast/Pelvic:
Rectal:

Back:

Extremities:

Neurologic:
Cranial nerves:
Motor:
Sensory:
Cerebellar:
Gait/Station:
Reflexes:

Data: Lab

Diagnoses:
Primary:
2.
3.

Plan: Health and safety issues were discussed. Will follow patient along with psychiatry.

_____ _____

Xxxxxx Xxxxxxx MD Date/Time
Staff Physician
Montana State Hospital

R:
T:

MONTANA STATE HOSPITAL
ANNUAL HISTORY & PHYSICAL
, 2014

MSH#:
Date of Admission:
Date of Evaluation:

Chief Complaint:
1.
2.

History of Present Illness: This patient is a admitted from

MEDICAL HISTORY: Hospitalizations: This is h admission Montana State Hospital (MSH). Past Psychiatric History: Past Medical History: Surgery:

Medications: Psychiatric: Medical:

Allergies:

Family History:

Social History:

Habits:

Review of Systems:
HEENT:
CVR:
GI:
GU:
NEURO:

PHYSICAL EXAMINATION

Temperature:	Pulse:	Respirations:
B/P:	Height:	Weight:
O2 SAT: 9		

General:

HEENT:
CVR:
GI:
GU:
Back:
Extremities:

 Annual Physical Examination:

Neurological:
Cranial nerves:
Motor:
Sensory:
Cerebellar:
Gait/Station: Romberg:
Reflex:

DATA: Lab

Diagnoses:
Primary:
2.
3.

Plan: Health and safety issues were discussed. We will continue to follow patient along with psychiatry.

Submitted by,

_____ _____

Xxxxx Xxxxx, MD Date/Time
Staff Physician
Montana State Hospital

R:
T: